LOCALISED MELANOMA RESECTED:

ADJUVANT THERAPY FOLLOWED BY SYSTEMIC RELAPSE

CLINICAL CASE PRESENTATION

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DISCLOSURE

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Clinical case 1 BRAF MUTANT MELANOMA

- Female in 20s, no comorbidities

Initial presentation: T4b N2a M0, stage IIIC melanoma

- **May-Sept 2018**: primary melanoma right posterior shoulder (5.8 mm, ulcerated, mitoses 7 per mm^2), WLE + SLNB right axilla (2/4 lymph nodes positive, no extracapsular extension). Right axillary node clearance (0/26 lymph nodes involved)
- **Oct 2018**: Restaging CT scan – subcutaneous nodules right scapula. Biopsy = melanoma.

  PET CT scan x 2 nodules right scapula, no distant metastases
- **Dec 2018**: Complete surgical resection. Histology = 2 deep subcutis lymph nodes containing melanoma (clear margins). Repeat CT scan clear

PET CT, positron emission tomography-computed tomography; SLNB, sentinel lymph node biopsy; WLE, wide local excision

QUESTION 1.

What adjuvant therapy would you offer this patient?

1. Nivolumab 3mg/kg every 2 weeks for 1 year

2. Dabrafenib 150mg twice daily plus trametinib 2mg once daily for 1 year

3. Pembrolizumab 200 mg every 3 weeks or 400 mg every 6 weeks for 1 year

4. No treatment

Clinical case 1 continued

- **Dec 2018**: commenced on adjuvant single agent nivolumab immunotherapy

- **Jan 2019**: Developed chest tightness and palpitations after three cycles

QUESTION 2.

What could likely be the cause of her symptoms?

1. Atrial fibrillation

2. Hypothyroidism

3. Hyperthyroidism

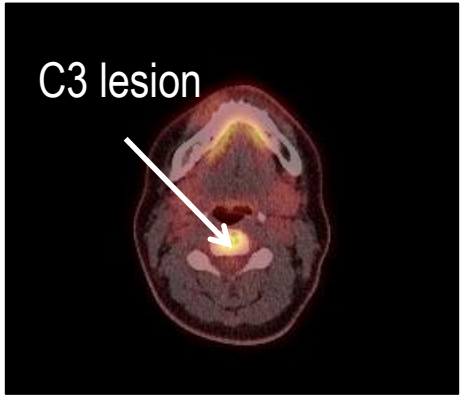
4. Anxiety

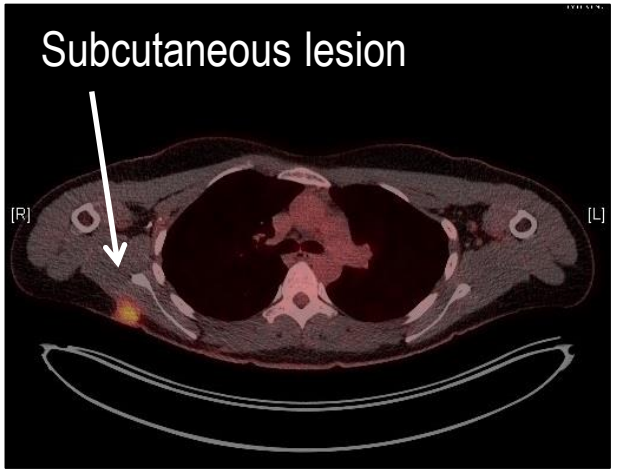
Clinical case 1 cont.

Relapse on adjuvant immune therapy

- **Jun 2019**: Following 12 cycles developed a further hard lump right shoulder. FNA done and confirmed melanoma.

- **Jul 2019**: PET CT scan showed subcutaneous lesion overlying the right scapula and a lytic lesion in the C3 vertebral body.





FNA, fine needle aspiration; PET CT, positron emission tomography-computed tomography

QUESTION 3.

What systemic therapy would you offer this patient?

1. Ipilimumab plus nivolumab

2. BRAF/MEK targeted therapy

3. Clinical trial

Clinical case 1 cont.

- **Jul 2019**: commenced on encorafenib binimetinib and had radiotherapy to C3 lesion

Clinical case 2 **BRAF WILD TYPE MELANOMA**

Patient in 50s, no comorbidities

- **Initial presentation: T2a N3a M0, stage IIIC melanoma**
- **May 2017**: primary melanoma excised from right arm (1.5 mm Breslow, non-ulcerated)
- **Aug 2017**: SLNB = positive with a 1 mm deposit
- **Nov 2017**: Axillary lymph node clearance - 3 out of 26 lymph nodes involved (upstaging patient from IIIA to IIIC)

SLNB, sentinel lymph node biopsy

QUESTION 1.

What adjuvant therapy would you offer this patient?

1. Nivolumab 3mg/kg every 2 weeks for 1 year

2. Dabrafenib 150mg twice daily plus trametinib 2mg once daily for 1 year

3. Pembrolizumab 200 mg every 3 weeks or 400 mg every 6 weeks for 1 year

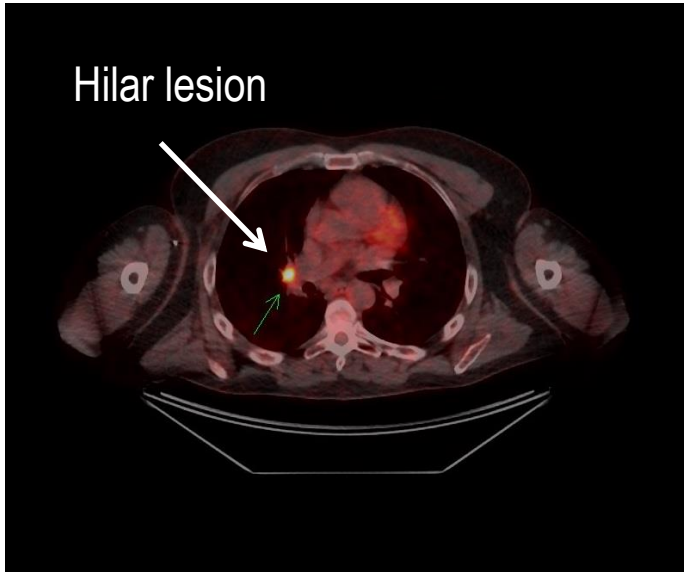
4. No treatment

Clinical case 2 continued

- **Jan 2018**: commenced adjuvant immunotherapy treatment within the CHECKMATE-915 study (ipilimumab+nivolumab vs. nivolumab)

Relapse on adjuvant immune therapy

- **Nov 2018**: PET scan showed a right lung nodule, right hilar lymph node and right femoral head lesion. Patient PS0, asymptomatic.
- Patient unblinded (received nivolumab)



PET, positron emission tomography

QUESTION 2.

What therapy would you offer this patient?

1. Ipilimumab 3mg/kg plus nivolumab 240mg 2wk/480mg 4wk

2. Ipilimumab 1mg/kg plus nivolumab 240mg 2wk/480mg 4wk

3. Ipilimumab 3mg/kg

4. Chemotherapy e.g. dacarbazine

5. Clinical trial

Clinical case 2 continued

- **Dec 2018**: Started ipilimumab + nivolumab. EBUS of right hilar lymph node - confirmed *BRAF* wild type melanoma

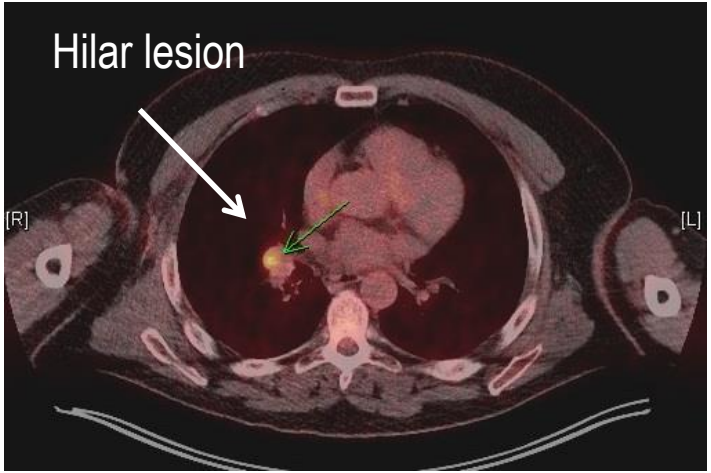
- **Jan 2019**: After x 2 cycles of treatment, developed a raised AST of 109 (G2) and high free T4 of 30 pmol/L (normal =10-22 pmol/L). Cycle 3 of ipi + nivo deferred

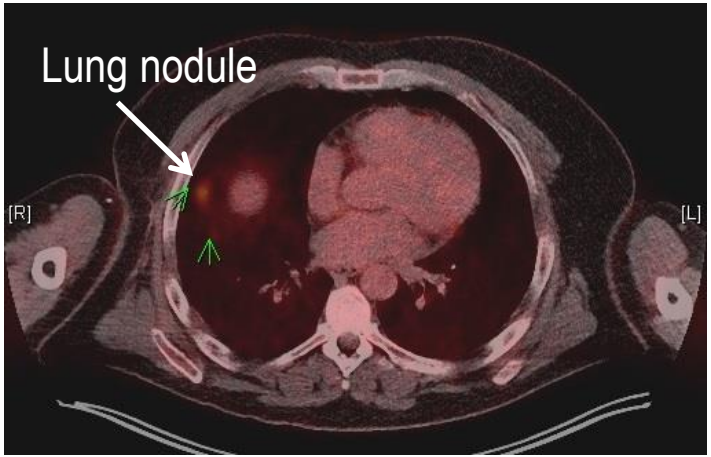
- **Feb 2019**: Proceeded with cycle 3. Subsequently developed grade 2 colitis - treated with i.v. methyl prednisolone 1mg/kg followed by oral prednisolone to which responded

AST,aspartate transaminase; EBUS, endobronchial ultrasound; i.v., intravenous

Clinical case 2 continued

- **Apr 2019**: Started nivolumab maintenance
- **May 2019**: Re-admission with diarrhoea and recommenced on steroids, however stool culture showed campylobacter infection
- **June 2019**: PET scan showed mixed response to therapy – hilar node responding, slight enlargement of right lung base nodule
- **Aug 2019**: Restarted nivolumab maintenance





PET, positron emission tomography

Thank you